

PART ONE: FAMILY THEORY

CHAPTER I

Why Family Therapy?

1. Family therapists deal with family pain.
 - a. When one person in a family (the patient) has pain which shows up in symptoms, all family members are feeling this pain in some way.
 - b. Many therapists have found it useful to call the member who carries the symptom the “Identified Patient,” or “I.P.,” rather than to join the family in calling him “the sick one,” or “the different one,” or “the one who is to blame.”
 - c. This is because the therapist sees the Identified Patient’s symptoms as serving a family function as well as an individual function.
2. Numerous studies have shown that the family behaves as if it were a unit. In 1954 Jackson introduced the term “family homeostasis” to refer to this behavior (39).
 - a. According to the concept of family homeostasis, the family acts so as to achieve a balance in relationships.

- b. Members help to maintain this balance overtly and covertly.
 - c. The family's repetitious, circular, predictable communication patterns reveal this balance.
 - d. When the family homeostasis is precarious, members exert much effort to maintain it.
3. The marital relationship influences the character of family homeostasis.
- a. The marital relationship is the axis around which all other family relationships are formed. The mates are the "architects" of the family.
 - b. A pained marital relationship tends to produce dysfunctional parenting.
4. The Identified Patient is the family member who is most obviously affected by the pained marital relationship and most subjected to dysfunctional parenting.
- a. His symptoms are an "SOS" about his parents' pain and the resulting family imbalance.
 - b. His symptoms are a message that he is distorting his own growth as a result of trying to alleviate and absorb his parents' pain.
5. Many treatment approaches are called "family therapy" but differ from the definition which will be presented here, since they are oriented primarily to family members as individuals rather than to the family as a unit as well. For example:
- a. Each family member may have his own therapist.
 - b. Or family members may share the same therapist, but the therapist sees each member separately.

- c. Or the patient may have a therapist who occasionally sees other family members “for the sake of” the patient.
6. A growing body of clinical observation has pointed to the conclusion that family therapy must be oriented to the family as a whole. This conviction was initially supported by observations showing how family members respond to the individual treatment of a family member labeled as “schizophrenic.” But further studies showed that families with a delinquent member respond in similar ways to the individual treatment of this member. In both cases it was found that:
- a. Other family members interfered with, tried to become part of, or sabotaged the individual treatment of the “sick” member, as though the family had a stake in his sickness.
 - b. The hospitalized or incarcerated patient often got worse or regressed after a visit from family members, as though family interaction had a direct bearing on his symptoms.
 - c. Other family members got worse as the patient got better, as though sickness in one of the family members were essential to the family’s way of operating.
7. These observations led many individually-oriented psychiatrists and researchers to re-evaluate and question certain assumptions (109, 110, 114, 140, 142, 146, 162).
- a. They noted that when the patient was seen as the victim of his family, it was easy to overidentify with and overprotect him, overlooking the fact that:
 - Patients are equally adept at victimizing other family members in return.
 - Patients help to perpetuate their role as the sick, different, or blamed one.
 - b. They noted how heavily transference was relied on in order to produce change.
 - Yet perhaps much of the patient’s so-called transference was really an appropriate reaction to the

therapist's behavior in the unreal, noninteractive, therapeutic situation.

- In addition, there was a greater chance that the therapeutic situation would perpetuate pathology, instead of presenting a new state of affairs which would introduce doubts about the old perceptions.
 - If some of the patient's behavior did represent transference (that is, his characteristic way of relating to his mother and father), why shouldn't the therapist help the patient deal with the family more directly, by seeing both the patient and his family together?
- c. They noted that the therapist tended to be more interested in the patient's fantasy life than in his real life. But even if they were interested in the patient's real life, as long as they saw just the patient in therapy, they had to rely on his version of that life or try and guess what was going on in it.
- d. They noted that in trying to change one family member's way of operating they were, in effect, trying to change the whole family's way of operating.
- This put the burden of family change-agent on the patient all by himself rather than on all family members.
 - The patient was already the family member who was trying to change the family's way of operating, so when he was urged to increase his efforts, he only received a more intense criticism from the family. This also led him to feel even more burdened and less able.
8. Aside from all these observations, once therapists started to see the whole family together, other aspects of family life which produced symptoms were revealed, aspects which had been largely overlooked. Other investigators of family interaction were making similar discoveries. As Warren Brodey sees it, the mates act differently with the normal sibling than they do with the symptomatic sibling (27):

... the parents in the presence of the "normal" sibling are able to relate with a freedom, flexibility, and breadth of awareness that one finds hard to believe, considering the limitations that exist in the

relationship between the parents when involved with the symptomatic sibling. The pathological ways of relating seem to be focused within the relationship with the symptomatic member. One wonders how this has come about.

9. But those psychiatrists who became increasingly devoted to family therapy were not the first to recognize the interpersonal nature of mental illness. Sullivan and Fromm-Reichmann, along with many other psychiatrists, psychologists, and social workers, were pioneers in this area of discovery. The Child Guidance movement was another important development which helped break the tradition of singling out just one family member for treatment (41).
 - a. Child Guidance therapists included both mother and child in treatment, even though they still tended to see mother and child in separate treatment sessions.
 - b. They also increasingly recognized the importance of including the father in therapy, though they found him hard to reach, and generally failed to engage him in the therapy process.
 - Therapists reported that the father felt parenting was his wife's job more than his; if the child acted disturbed, his wife was the one who should be seen.
 - The Child Guidance therapists, being mother-child oriented anyway, tended to agree with the father's reasoning, so they could not easily convince him that his role in the family was important to the health of his child.
 - Child Guidance Clinics remained primarily focused on "mothering," even though they increasingly recognized the importance of "fathering." And whether or not they included the father in their thinking, they continued to focus on the husband and wife as parents of the child rather than as mates to each other. Yet it has been repeatedly noted how critically the marital relationship affects parenting. Murray Bowen writes, for example (25):

The striking observation was that when the parents were emotionally close, more invested in each other than either was in the patient, the patient

improved. When *either* parent became more emotionally invested in the patient than in the other parent, the patient immediately and automatically regressed. When the parents were emotionally close, they could do no wrong in their “management” of the patient. The patient responded well to firmness, permissiveness, punishment, “talking it out,” or any other management approach. When the parents were “emotionally divorced,” any and all “management approaches” were equally unsuccessful.

10. Family therapists have found it easier to interest the husband in family therapy than in individual therapy. This is because the family therapist is himself convinced that both architects of the family must be present.
 - a. Once the therapist convinces the husband that he is essential to the therapy process, and that no one else can speak for him or take his place in therapy *or* in family life, he readily enters in.
 - b. The wife (in her role as mother) may initiate family therapy, but once therapy is under way, the husband becomes as involved as she does.
 - c. Family therapy seems to make sense to the whole family. Husband and wife say: “Now, at last, we are together and can get to the bottom of this.”
11. Right from the first contact, family therapists operate from certain assumptions about why a family member has sought therapeutic help.
 - a. Usually the first contact is made because someone outside the family has labeled Johnny as disturbed. This first contact will probably be made by an anxious wife (we will call her Mary Jones), acting in her role as mother of a disturbed child, Johnny. The child is disturbed, so she, the mother, must be to blame.
 - b. But Johnny was probably exhibiting disturbed behavior long before he became labeled disturbed by someone outside the family.

- c. Until the outsider (often a teacher) labeled Johnny as disturbed, members of the Jones family probably acted as though they did not notice Johnny's behavior; his behavior was appropriate because it served a family function.
 - d. Usually some event has occurred which has precipitated symptoms in Johnny, symptoms which make the fact that he is disturbed obvious to outsiders. These events are:
 - Changes from outside the nuclear family: war, depression, etc.
 - Changes in the two families of origin: sickness of a grandmother, financial distress of a grandfather, etc.
 - Someone enters or leaves the nuclear family: grandmother comes to live with the family, the family takes on a boarder, the family adds to its membership with the birth of another child, a daughter gets married.
 - Biological changes: a child reaches adolescence, mother reaches menopause, father is hospitalized.
 - Major social changes: a child leaves home to attend school, the family moves to a new neighborhood, father gets a job promotion, son goes to college.
 - e. These events can precipitate symptoms because they require the mates to integrate the changes. This requirement puts an extra strain on the marital relationship because it calls for a redefinition of family relationships and thus affects family balance.
 - f. The family homeostasis can be functional (or "fitting") for members at some periods of family life and not at other periods, so events affect members differently at different times.
 - g. But if one member is affected by an event, all are to some degree.
12. After the first contact with Mary Jones, the therapist may speculate about the relationship between Mary and her husband, whom we will call Joe. If it is correct to assume that a dysfunctional marital relationship is the main

contributor to symptoms in a child, the relationship between the mates will be the therapist's first concern.

- a. What kind of people are Mary and Joe? What kind of families did they come from?
 - Once they were two separate people who came from different family environments.
 - Now they are the architects of a new family of their own.
- b. Why, out of all the people in the world, did they choose each other as mates?
 - How they chose each other gives clues to why they may now be disappointed with each other.
 - How they express their disappointment with each other gives clues to why Johnny needs to have symptoms in order to hold the Jones family together.